North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services
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Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

Michael Moseley, Director

June 16, 2004

MEMORANDUM:

TO: Area Directors

FROM: Phillip Hoffman, Chief
Resource and Regulatory Management Section
DMHDDSAS

Laketha M. Miller, Controller
DHHS Office of the Controller

RE: LME Funding Mechanism Effective July 1, 2004 – Payment and Settlement Process

Effective July 1, 2004, LME funding for system management functions will be provided by the Division as a direct funding stream rather than the previous method of having area program administrative cost included as a component of service payments. The purpose of this communication is to provide an overview of how this process will take place, from payment through year-end settlement. The narrative information contained in this memo is also supplemented with a copy of the required LME reporting form. This communication only addresses the items/costs related to LME system management functions (those outlined in the LME Cost Model) and does not address allocations for the provision of consumer services.

I. The Allocation and Payment Process

a. The Division will work with each LME to determine its annual LME system management allocation, which will be made in the form of a formal allocation letter to each approved LME. All final LME allocations will be issued by the Division by June 24, 2004.

b. Based on the LME allocation for SFY 05, beginning in July 2004, LME payments will be made on a monthly $1/12^{th}$ basis during the year. Payment will automatically be made each month to the LME, therefore, it will not be necessary for the LME to "bill" for these payments. LMEs will, however, be required to report expenditures on a monthly basis to (1) enable the DHHS Controller's Office to draw in Federal Medicaid funds which support LME cost and to monitor those earnings, and (2) allow the LME and Division to monitor the expenditure of funds. Reporting requirements are described in Section II below.

c. Total LME cost will be allocated between State and Medicaid based upon an approved cost allocation plan. The approved cost allocation plan will be handled by the Division and DHHS Controller's Office and, for all practical purposes, should be invisible to the LMEs.

Systemwide, the Division anticipates that total LME payments will be approximately $153.8m, with $63.6m of that being earned via Medicaid payments and the balance of $90.2m coming from State funds.

d. A general overview of the cost allocation aspect for LME payments and the corresponding receipt of Medicaid funds is as follows – example based on statewide estimates:

1. The cost allocation plan includes earning Medicaid receipts at a 50-50 matching rate for most expenditures, however, reimbursement is available at a 75-25 matching ratio for qualified medical professional (QMP) staff performing functions which require a QMP [42 CFR 432.50 (d)]. QMPs in

the DMH/DD/SAS system are defined in administrative rule at 10A NCAC 27G.0104 (18). Within the LME cost model, the functions which require QMPs are (i) Access, Screening, Triage & Referral, (ii) Provider Relations and Support, (iii) Service Management, and (iv) Customer Services. In order to qualify for the enhanced 75-25 Medicaid reimbursement rate, there are two key considerations – (i) the QMPs must be public employees, i.e., employees of the LME [area authority or county program] or contracted through another public entity; if the functions which potentially qualify for enhanced 75-25 funding are contracted to a private organization, they are only reimbursable at the 50-50 Medicaid rate, regardless of whether the function is performed by a QMP or not since the federal regulations require them to be performed by a State or local governmental employee, and (ii) the QMP must be performing functions which require a qualified professional. For example, an M.D. performing service management functions would qualify for 75-25 funding however, an M.D. serving as the LME CEO would not qualify for enhanced funding since general LME governance is not a function reimbursable at the 75-25 rate.

The categories in Section II.b. below are designed to capture total LME expenditures and to further segregate costs for QMPs (and their direct support) performing functions which qualify for enhanced 75-25 Medicaid reimbursement.

2. Another key element of the cost allocation plan is determining what portion of total LME expenditures may reasonably be allocated to Medicaid for reimbursement. To arrive at this, the Division pulled line item claims billing data and determined what percent of the lines billed were for Medicaid payment and what percent were for non-Medicaid. This information was looked at for (i) claims which flowed through the area program, and (ii) total claims managed by the LME – which are inclusive of those flowing through area programs, direct billings and billings from State operated facilities. On a statewide basis, for the first quarter of SFY 2003-2004, 57% of the lines of claim flowing through area programs were for Medicaid reimbursement, and 67% of total lines of claims billed for services managed by the LME, including direct billed services, were for Medicaid reimbursement.

   These statistics are important since they are applied in the following manner as they relate to monthly reporting outlined in item 2 below and the following examples (Note: The statistics will be updated each month. We have used the information from the first quarter of SFY 2003-2004 for illustrative purposes only):

   (i) $10,000 reported for Claims Processing (billings flowing through the LME for payment) is multiplied by 57% (lines of Medicaid claims flowing through the LME) and then multiplied by 50% (Federal Medicaid reimbursement rate for Claims Processing function). Resultant Medicaid earnings are $2,850 ($10,000 x 57% x 50%).

   (ii) $20,000 reported for Service Management performed by QMP is multiplied by 67% (lines of total claims managed by LME) and then multiplied by 75% (Federal Medicaid reimbursement rate for this function provided by a QMP). Resultant Medicaid earnings are $10,050 ($20,000 x 67% x 75%).

<u>An important aspect in these examples is that there is NO county share required as match for the Medicaid payment. The full non-Federal share of the Medicaid reimbursement is provided by the Division with State funds</u>.

II. Required Monthly Reporting ("Monthly LME Report of Expenditures): Refer to Attachment 1.

a. Attached is the required reporting form – "Monthly LME Report of Expenditures" - which each LME must submit on a monthly basis. The report is to be submitted by the 15th calendar day following the end of the previous month. For example, July's expenditure report will be due August 15, August's expenditure report will be due September 15, and so on. In order to review and record the appropriate Medicaid expenditures, the "Monthly LME Report of Expenditures" is to be sent to:

   George Francis
   DHHS Office of the Controller
   2019 Mail Service Center
   Raleigh, NC 27699-2019

b. The "Monthly LME Report of Expenditures" is comprised of 4 parts, with each part related to the cost allocation method DHHS will use to earn Medicaid dollars. These parts are:

1. Total Expenditures for Claims Processing – Less Purchases of Equipment or Other Depreciable Assets. Medicaid reimbursement is earned on these costs based on: actual cost x Medicaid percentage of lines of claims billed through Area Programs x 50%.
2. Salary and Fringe Benefits Cost of Qualified Medical Professional and Their Direct Support Staff. Medicaid reimbursement is earned on these costs based on actual cost x Medicaid percentage of all lines of claims billed for MH/DD/SA services x 75% (provided the QMPs are providing activities which also qualify for the enhanced Medicaid reimbursement rate).
3. All Other Expenditures – Less Purchase of Equipment or Other Depreciable Assets. Medicaid reimbursement is earned on these costs based on actual cost x Medicaid percentage of all lines of claims billed for MH/DD/SA services x 50%.
4. Monthly Depreciation and Indirect Cost. Medicaid reimbursement is earned on these costs based on monthly depreciation and actual indirect cost x Medicaid percentage of all lines of claims billed for MH/DD/SA services x 50%.

III. Year-End Settlement

The year-end settlement process is necessary to ensure that Medicaid payments are settled based on actual costs. While there is a year-end settlement process for Medicaid funds, there is no year-end settlement process for State funds. State funds paid within the overall LME allocation that are not expended will roll into the LME's fund balance, subject to the 15% limitation.

The following is an example of year-end settlement:

Year End Settlement		
Total LME System Management Payments		6,500,000
Total Actual Expenditures		6,043,001
Unspent Balance (to Fund Balance)		456,999
Allowable Medicaid Cost	3,968,812	
Medicaid Cost Reimbursed	3,968,812	
Medicaid Cost Settlement Due	0	

Actual cost are reported by the LME on a monthly basis and the monthly cost allocation plan applies the relevant lines of claims billing percentages (based on totals for the State) for Medicaid vs. non-Medicaid and Medicaid funds are earned on a reimbursement basis. Unless there were errors in the reporting of monthly cost, including their categorization as related to QMPs, allowable cost, etc., all Medicaid funds should have been appropriately earned throughout the year.

In the event an LME spends more than its LME allocation from the Division, the LME will be totally responsible for defraying any over-expended amounts.

IV. General Information and Potential Pitfalls

While each LME will earn Medicaid reimbursement based on its individual expenditures and utilization of QMPs for enhanced reimbursement, the Division intends to monitor the flow of Medicaid receipts at the State level. In item 1.c. above, the estimated total LME payments will be approximately $153.8m, with an estimated $63.6m coming as the Federal share of Medicaid payments. As long as earnings from all LMEs collectively are pretty much on target to generate this level of Medicaid reimbursement, things will be fine. This allows for some programs to earn more Medicaid funds than projected, while some others may earn less than projected.

If an LME earns more Medicaid than anticipated on a statewide average, this does not mean that that LME will be able to spend above the level of aggregate funding allocated by the Division and expect to receive additional payments from the Division. On the other hand, an LME which earns somewhat less Medicaid than anticipated will not have its overall LME allocation reduced. This plus and minus on Medicaid earnings will be monitored and managed at the State level and again, as long as the Medicaid numbers are relatively close to projections on a statewide basis, the Division's budget can handle a reasonable level of variance.

On the pitfall side, if the Medicaid earnings are significantly less than projected on a statewide basis and reach a deficit which the Division's cannot reasonably handle by realigning resources, the Division will most likely be forced to initiate discussions with LMEs in order to formulate a plan for coping with such a shortfall. Such a plan could include each LME assessing its reporting accuracy to ensure enhanced Medicaid reimbursement is being optimized, voluntary expenditure limitations by LMEs or having the Division institute LME funding reductions in order to operate within its available resources. With accurate monthly reporting, monitoring and timely feedback to LMEs of Medicaid earnings, problems of this nature can hopefully be avoided.

Should you have any questions concerning this communication, please contact me at 919-715-7774 or via e-mail at Phillip.Hoffman@ncmail.net

This communication and the attached reporting form are also being placed on the Division's public web page under "Announcements".

PDH/ph

Attachment

cc:
Area Finance Officers
County Managers
Secretary Carmen Hooker Odom
Lanier Cansler
James Bernstein
DMHDDSAS Exec. Leadership Team
Carol Duncan Clayton
Robin Huffman
Mike Mayer
Bob Hedrick
Patrice Roesler
Dick Oliver
Kaye Holder
Wanda Mitchell
DMHDDSAS Budget & Finance Team
Jack Chappell
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